SPRINGFIELD MEDICAL CARE SYSTEMS (SMCS)

WINDHAM CENTER

CONCEPTUAL PROPOSAL
For
PSYCHIATRIC ACUTE CARE SERVICES
TO REPLACE VERMONT STATE HOSPITAL

August 26, 2009

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EXECUTIVE SUMMARY

Springfield Medical Care Systems and its psychiatric and substance abuse service continuum - The Windham Center - wish to partner with Vermont Department of Mental Health (DMH) and all community stakeholders to create a continuum of recovery oriented, integrated, medically capable, co-occurring disorder capable, and trauma informed acute care services that meets and exceeds all expectations defined by DMH in its Request for Proposals (RFP) for Vermont State Hospital (VSH) Replacement Capacity, and in the Guiding Principles of Collaboration between DMH and Designated General Hospitals.

The continuum of services will be seamlessly integrated to facilitate movement of each consumer into the least restrictive setting that effectively empowers the consumer to make the most effective progress in maintaining safety and in achieving his or her recovery goals. This continuum will be anchored by 10 acute care beds which will be specifically designated as VSH Replacement Beds as defined in the RFP, and will also include access to a continuum that includes 10 Medically Monitored Crisis Stabilization Beds, Partial Hospitalization, Intensive Outpatient Programming, Dialectical Behavior Therapy Programming (DBT), Intensive Short Term Crisis Case Management, Peer Support, and a network of short term and continuing community based outpatient services provided in collaboration with community partners such as Health Care and Rehabilitation Services of Southeastern Vermont (HCRS).

The Windham Center has considerable experience and expertise in the delivery of a recovery oriented, co-occurring capable, trauma-informed continuum of services. Our expertise in this area has long been recognized by both DMH and by Vermont Psychiatric Survivors. We are proposing to use our existing expertise, and our available physical plant to create a continuum that meets the needs of DMH in the following ways:

- Rapid implementation with a need for relatively minimal capital investment as the continuum is developed primarily within existing space
- 24-hour, 7 day-a-week welcoming access to admission for consumers with complex and challenging conditions with no one turned away due to psychiatric acuity or medical complexity
- Development of a 10 bed Medically Monitored Crisis Stabilization Unit on campus allowing patients to access appropriate levels of care on the continuum
- Radical commitment to consumer and family driven care, with active involvement of peer support throughout the continuum and the utilization of trauma-informed, non-violent strategies to effectively engage consumers in participation in their care
- Integration of medical capability and medical staffing on site, as well as 24 hour ready access to all acute and ancillary medical services at Springfield Hospital and full organizational integration and physical co-location with Federally Qualified Health Center
- Commitment to recovery oriented, co-occurring capable programming throughout the continuum

- Capacity to help consumers move rapidly to lower levels of care while maintaining continuity of treatment team in order to promote empowerment for consumers as well as facilitation of access for admission to the highest levels of care
- Consistent incorporation of DBT programming and principles throughout the continuum
- Access to designated transportation services for all consumers
- Commitment to ongoing partnership with families and community caregivers
- Commitment to empowering the community in overseeing the quality of service provision and participating in quality improvement activities in accordance with the Guiding Principles

The specific elements of how this vision will be operationalized are described in the following proposal.

I. Conceptual Proposal

The following proposal is a conceptual proposal rather than a formal bid. There are two categories of issues that have to be addressed and resolved by Springfield Medical Care Systems/Windham Center prior to making a formal bid.

A. Planning Issues: The first category of issues relates to the planning process. Because of our recent leadership transition, and the rapid turnaround time in the RFP process, we have not had an opportunity to engage in the types of collaborative planning with our internal and external stakeholders that we feel would be necessary in order to create a final proposal. We are proposing to begin this planning process in the context of submission of this conceptual proposal but would anticipate that the process itself would need to continue for 3 to 6 months in order to ensure that all stakeholders were on board and fully supportive of the formal proposal.

B. Structural and Financial Issues: While there are no major regulatory barriers that have to be overcome in order for us to proceed with a formal proposal and a process of implementation if the proposal is approved, there are several structural, regulatory, and financial issues that need to be clarified before we can formally proceed. They are listed below:

- Our proposal is contingent on the development of 10 Medically Monitored Crisis Stabilization beds that would allow the current patient population to step into appropriate level of services. We need to establish that such beds would not be construed as "inpatient hospital beds" by regulatory agencies that govern our status as a Critical Access Hospital. TIME FRAME – 3-6 months.

- Our current space and the space into which we would be expanding is not owned by Springfield Hospital. We would have to develop formal agreements regarding the space with Greater Rockingham Area Services (the owner and leaser), HCRS (current occupant of some of the space we will need), and DMH to define a viable and stable model for availability of the space for this project. TIME FRAME – 3-6 months.

- With regard to the Crisis Stabilization Unit component of our proposal, we need clarification regarding the requirements for a certificate of need, licensure, and local zoning for this aspect of the project. TIME FRAME – 3 months.

- With regard to the space aspects of our proposal, we have not had time to conduct a comprehensive assessment of the costs and needs of renovating available space for either the Replacement Unit or the Crisis Stabilization Unit. TIME FRAME – 3 months.

- With regard to the financial aspects of our proposal, we are in the midst of a period of considerable uncertainty in Vermont regarding hospital reimbursement generally, and reimbursement for Springfield Hospital in particular. In order to guarantee that our proposal would be financially viable much of this uncertainty needs to be resolved prior to the development of a formal budget for our proposal. TIME FRAME – 3 months.

- With regard to the organizational aspects of our proposal, Springfield Medical Care Systems has recently (June 1, 2009) received designation as a Federally Qualified Health Center. The FQHC designation has become the umbrella for most of our non-hospital services. Because our designation as an FQHC is relatively recent all the financial and organizational implications of that structure have not yet been realized. Consequently, we cannot make a formal proposal until we have more clarification on these issues. TIME FRAME – 3 months.

- Last, but certainly not least, we need to have continued conversations with DMH to determine a contracting model that insures continued guarantees that the state will provide resources that will support our commitment to the program and the population. We are reluctant to commit to providing VSH replacement beds at higher cost than conventional beds without a reasonable plan for addressing the risk that additional reimbursement could be withdrawn in the future, while our obligation to provide the same level of care would continue. We are expecting that DMH will be working with us in good faith on this issue but we need further assurances before we proceed with a formal proposal. TIME FRAME – 3 – 6 months.

II. Bid Requirements

A. Organizational Description: Springfield Medical Care Systems (SMCS) is a non-profit corporation directed by a dedicated Board comprised of patients and community members. SMCS defines its service area as 14 towns located in the Vermont counties of Windsor (eight towns) and Windham (three towns) and the New Hampshire Counties of Sullivan (two towns) and Cheshire (one town). SMCS provides and coordinates care for the service area population from nine (9) clinic sites located in the Vermont towns of Springfield (five locations), Ludlow, Rockingham and Chester and Charlestown, NH. SMCS includes Springfield Hospital, a Critical Access Hospital (CAH). The mission of SMCS is to provide preventive and primary health care and to maintain, improve and expand access to and ensure the availability and coordination of community-based health care and related services. From strategically dispersed clinic sites, SMCS provides comprehensive primary care, behavioral health counseling and supportive and ancillary services to nearly 25,000 individual users.

Springfield Hospital is a 25-bed Critical Access Hospital. Springfield Hospital is governed by a Board of Directors comprised of community members representing our service area. Services provided by Springfield Hospital include both inpatient and outpatient care in the following areas: behavioral health, obstetrics, medicine, surgery, and emergency care. Diagnostic, treatment, and wellness services are also provided by Springfield Hospital. The Windham Center is a department of Springfield Hospital.

The Windham Center is the psychiatric/mental health services division of Springfield Hospital We are part of the state's designated hospital system and were the first community hospital to achieve this designation (1997). Windham Center is located in Bellows Falls, and is integrated with Rockingham Medical Group, part of our Network of Community Health Centers (FQHC).

For the past decade, the Windham Center's vision has been to operate as a full partner in the DMH system of care. Jim Walsh RN, one of the Windham Center's Co-Directors, has been a longstanding member of the State Standing Committee, and has been an active participant in the Futures Project and the Care Management Steering Committee. We know the patients served by VSH and we like working with those patients who are most in need. We regard this project as an opportunity to develop the kind of resources that we have never previously had in order to be able to implement our vision. Further, as a result of Springfield Hospital's designation as a critical access hospital, we have had to reduce our inpatient capacity to 10 beds from our former 20-bed licensed capacity. This project

will also allow us to restore and expand our ability to provide the range and the volume of services that has always been a priority in our strategic vision. We welcome the opportunity to work in partnership with DMH to achieve these goals.

The Windham Center currently provides both an inpatient and outpatient continuum of care. The inpatient hospital level of care includes a 10-bed secure inpatient unit and the outpatient continuum includes a Partial Hospitalization Program, Dialectical Behavior Therapy Program, Outpatient Buprenorphine program, Intensive Outpatient Programs, and conventional outpatient services. The Windham Center outpatient services provide psychopharmacology, individual and group therapy, including a specific service array for pain management. Jean Etter LICSW, Co-Director for Windham Center, focuses her work around outpatient programming, clinical leadership, and DBT.

The Windham Center is recognized for its commitment to value driven services and value driven organizational principles. We engage our staff as partners, along with consumers, in the development and implementation of our vision. Consequently, we have a dedicated staff with a longstanding commitment to working with the people we serve. The Windham Center has been able to retain highly qualified, dedicated employees as evidenced by a less than 2% annual turnover. Our retention of staff translates into our ability to provide a high quality of patient care.

Windham Center has a long history of being a client centered, recovery oriented organization that works closely with Vermont Protection and Advocacy and Vermont Psychiatric Survivors, and was the first hospital in the state to have formal recovery training for all staff and to develop a consumer satisfaction survey that provides confidential results directly to VPS to be used as input into our quality improvement process.

Windham Center has an equally long history of welcoming co-occurring disorder clients with emphasis on providing comprehensive, continuous, integrated stage based treatment, and was the only inpatient unit to participate in the initial CCISC implementation project for statewide co-occurring capability development. All programs throughout the continuum are co-occurring capable as well as trauma-informed and DBT informed.

All of our staff is co-occurring disorder competent. In addition, we employ Dr. William Grass, a board certified addiction Psychiatrist along with an interdisciplinary team of Psychiatrists, Nurses, Masters level clinicians; Social Workers and Masters level Licensed Alcohol & Drug Counselors.

Furthermore, the Windham Center outpatient DBT program, open since 2003, is recognized as one of only two free standing (outside the designated

agencies) DBT programs in Vermont. Our Co-Director, Jean Etter LICSW is a member of the State DBT Development Committee and is an experienced DBT trainer. In the past five years, we have trained over 50 practitioners and continue to be available to the designated agencies for on-going training and consultation across the state.

Additionally, in the past two years, Springfield Hospital and the Windham Center have taken dramatic steps to improve the capacity to deliver integrated health and behavioral health services on site in Bellows Falls. Rockingham Medical Group has been designated as a Federally Qualified Health Center and we have co-located behavioral health services within this footprint. We have enhanced cross consultation between the medical clinic, walk in care, and the Windham Center, and improved the medical capability of all our psychiatric services. Further, we have begun to create a unique community partnership to address the issue of chronic pain and opiate abuse.

B. Program Description:

Our program description emphasizes a continuum of care with several different components, both inpatient and outpatient, and incorporates many of the levels of care that have been identified in the Vermont Care Management System report. In this program description, we will emphasize the replacement beds and the crisis stabilization unit beds but will also provide brief descriptions of other elements of the proposed continuum.

1. 10-Bed Acute Psychiatric Inpatient Unit (ICU): *This level of care corresponds to the following level of care in the Vermont Care Management System report: Level 6.5: Medically Managed, Highly Acute, Secure Inpatient Services.*

Windham Center is proposing that our entire current 10 bed inpatient psychiatry unit will be converted to a 10 bed locked and secure unit with ICU capability. The unit will be designed as a "Zero Reject" setting, with the capacity to admit any patients referred who need psychiatric acute inpatient admission, regardless of level of psychiatric acuity and medical complexity. Length of stay would be variable, with many consumers staying 9-30 days, with a few consumers requiring as long as 45-60 days. Individuals with active co-occurring substance use will be welcomed. All interventions will be designed to assess and stabilize and to be recovery oriented and trauma informed. We recognize the need to inspire people with the hope of a productive happy life and are sensitive to the likelihood that the individual has experienced previous trauma and should not be re-traumatized.

As will be described in subsequent sections of this proposal, the ICU will require a space design that permits individuals who may be very agitated and unstable to have safe and quiet space. This will allow separation from other patients on the unit who may be upset by individuals who may be out of control. Further, in addition to the standard staffing and programming of a typical inpatient unit, the level of staffing for the ICU component will be enhanced so that individuals who need 1:1 staffing, secure interventions to help facilitate de-escalation, or other intensive staff level of support can be provided those interventions on an immediate basis.

Because of the existing philosophy and capabilities of the Windham Center, the ICU will be designed to have some radical and unique features. We believe that access to peer support at all times will facilitate engagement of consumers and reduce the need

for involuntary and/or restrictive interventions. Consequently, we plan to include trained peer specialists in all categories of milieu staff including staff designated primarily to provide "security" functions. All staff will be trained in non-violent de-escalation and in engagement of individuals who have been involuntarily admitted who are frightened about their loss of control. Further, we will be aggressive about seeking alternatives to restraint and seclusion and will have all staff trained in the principles of DBT and trauma-informed engagement to assure that the ICU experience re-traumatizes the patient as little as possible. Further, we will develop a welcoming, hopeful, recovery oriented atmosphere, that engages individuals with any combination of mental health and substance use issues. We will have recovery oriented, strength based, skill development, co-occurring capable programming throughout our program milieu, including WRAP facilitation, as this is consistent with the programming we are already providing.

Additionally, the unit will be designed to have full medical capacity. This will include 24-hour physician availability on site with two of the 10 beds designed specifically as "medical beds" (with all the appropriate equipment). We intend to incorporate a medical physician and/or nurse practitioner as part of the staffing pattern. There will be on site capability for routine blood drawing, EKG, and X-ray services. 24-hour access to transport for laboratory and other medical testing not available on site and urgently needed (e.g, CAT scanning) will be provided. We will provide capacity for psychiatric staffing for individuals who need a higher level of medical care (e.g., cardiac monitoring) in order to safely manage those patients at Springfield Hospital. Access to ECT will be provided for. The goal is that any patient with medical co-morbidity, who does not need an acute medical admission, emergency medical intervention, or 24-hour nursing home level of care can be safely admitted and managed.

Admission Criteria: LOCUS scoring for level 6, plus a checklist of additional criteria as defined below.

This level of care is for individuals who meet psychiatric inpatient level of care and who meet one or more of the following criteria that would render them unable to be admitted and managed safely in a standard inpatient unit.

- The individual has a high likelihood of violent behavior and needs close monitoring to maintain safety as well as separation from other patients who may be endangered

- The individual needs intensive staffing over an extended period of time (e.g., at least 24 hours) due to the likelihood of harmful behavior and a low level of self-management capability
- The individual is choosing not to accept medications and has a high likelihood of engaging in dangerous behavior
- The individual's level of agitation and distress necessitates some degree of separation from the unit milieu for an extended period
- The individual is highly disorganized and unable to make decisions to the extent that they could present a safety risk to themselves or others

In most instances individuals admitted to ICU level of care will be admitted involuntarily but some individuals may be voluntary. Some individuals may choose or request ICU level of care as part of an individual crisis plan in order to promote restabilization and reduce the likelihood of further decompensation. Where possible, such requests will be respected. In addition, for a variety of reasons (e.g., consumer choice and geography), we would expect that some patients would be admitted who would be at standard inpatient level of care but would choose the Windham Center as their preferred option for hospitalization. These individuals would ideally be rapidly transitioned to Crisis Stabilization (see below).

Discharge and Transition Criteria: Once the individual demonstrates the ability to manage safely for 24-48 hours within the parameters of staffing provided by a standard inpatient unit, and is engaging regularly in the milieu, the individual may be considered for transfer to standard inpatient level of care in a designated hospital closer to their home community, or to Medically Monitored Crisis Stabilization level of care on the Windham Center campus. It is our goal in this model to facilitate rapid transitions to the least restrictive level of service. We have observed that a very high proportion of individuals currently receiving standard acute inpatient care at the Windham Center could be managed successfully in an appropriately designed crisis stabilization unit if that unit were truly seamlessly integrated into the continuum of care. Individuals should be retained in the ICU only if they are unable to be safe and successful in any other setting. Consequently, we are envisioning that individuals will be transitioned as quickly as possible while maintaining some continuity of programming and continuity of treatment team. In addition, the proximity of the ICU would permit rapid access to a higher level of care if the individual began to decompensate in the crisis bed setting.

2. **10-Bed Medically Monitored Crisis Stabilization Unit:** *As described in the Vermont Care Management System report, this level of care is described as Level 5.6, and corresponds to an adaptation of Locus Level 5, Medically Monitored Residential Services.*

SMCS and Windham Center are proposing the development of a 10-bed crisis stabilization unit on the Bellows Falls campus. Many space options are possible. For the purpose of this conceptual proposal the most likely option will be the conversion of the Credit Union building across the parking lot from the Health Center at Bellows Falls (within which the Windham Center inpatient unit is located). This building would be converted to have two floors of residential space, with one and two bed rooms, as well as program and staff space. We would also plan to house some current outpatient programs in this same building (outpatient psychiatry, outpatient groups, IOP, PHP, DBT) so that individuals in the crisis stabilization unit would have easy access to programming that was individually matched to their needs.

The 10-bed Crisis Stabilization Unit program would be a recovery oriented, co-occurring disorder capable, trauma-informed, staff supported, medically and nursing monitored community based residential setting. The CSU will be designed to provide a safe environment for crisis resolution for individuals who might otherwise be at risk of hospitalization or of further deterioration if in a community based setting with lesser support. This program is a lower level of care than hospital level of care and would be designed as an unlocked, voluntary, residential, home-like setting with 24 hour staffing. Length of stay may be as short as 24 hours, and may range up to 14 days. Admissions would occur 24 hours per day, 7 days per week, including both direct admissions and stepdowns from inpatient units. The treatment team would include a program manager and nursing on site 8 hours per day 7 days per week (which may also provide nursing support for PHP and Buprenorphine programming). A minimum of two case management support staff would be on site for each shift. One of which would be a certified peer support specialist. Further, there would be access to nursing consultation on-call at all times in the event that medication or health questions arise. In addition, the consumers in the crisis stabilization unit would have routine access to psychiatric evaluation and medication monitoring from outpatient psychiatry staff on site a minimum of 3 days per week, with 7 day per week availability if needed. The CSU program will also have the capacity to achieve initial stabilization of substance use including access to medication to alleviate withdrawal symptoms. However, there will not be routine daily psychiatric

management as there would be on an inpatient unit Finally, on campus security would be able to provide coverage for this site in the event of a behavioral crisis but would not be located in the building itself.

The major program elements include adjustment of medication, professional and peer support, crisis intervention, case management, linkage with family and community supports, and some individual and/or group counseling. There will be no barriers to admission based solely on psychiatric diagnosis, medical diagnosis, or presence of active substance use disorder, and consumers will have access to the full complement of enhanced on-site health and dental services available on campus.

Admission Criteria: The CSU is intended to manage individuals with acute psychiatric decompensation or crisis in combination with all types of medical, cognitive, and substance abuse co-morbidity who otherwise meet the clinical criteria for hospital admission. The CSU setting would be appropriate for those individuals who can be maintained and engaged in an unlocked, staff supported, residential setting, and do not require hospital level of security.

Our concept is that the crisis stabilization unit is embedded in a continuum of higher and lower levels of care that provide both the capacity to serve more individuals in a non-hospital setting who might otherwise need conventional hospitalization, as well as to permit the most flexible utilization of resources. In this regard, we propose to embed the unit in the same location as our existing outpatient group programs (PHP, IOP, DBT) and to facilitate consumers in the crisis stabilization unit to have access to the group programming that is best matched to their needs. All programming is recovery oriented, trauma informed, and co-occurring capable. Some individuals would attend only a few groups and focus more on receiving individual crisis intervention, medication adjustment, and peer support. Other individuals might have all of the above but also have extensive participation in programming according to individual need as determined in their interdisciplinary recovery plan constructed in partnership between the consumer, family (if involved), and the treatment team.

Discharge Criteria: Individuals who have stabilized and are able to function at a lower level of care in a community setting would be considered for discharge. An individual requesting a change in level of care and who has demonstrated the ability to return home or to a residential setting with appropriate supports in place would

also be considered appropriate for discharge. In some instances the discharge plan will require step up to a higher level of care including an acute inpatient psychiatric unit. Note that many individuals receiving service in the acute care continuum may not be CRT eligible, or, if eligible, admitted to CRT, but may need short to intermediate term intensive community based case management in order to stabilize sufficiently to be able to progress successfully in routine outpatient care. This component of the continuum is described below.

3. Intensive Community Based Crisis Intervention

As described in the Vermont Care Management Report, this level of care corresponds to Locus Level 4.1, an adaptation of Locus Level 4, Medically Monitored Non-Residential Services. Some individuals served by this program may require high intensity crisis stabilization without medical monitoring, but it will be most efficient for both of these types of services to be "bundled" into a single program and a single team which is able to accommodate a range of flexible interventions matched to client need.

We recognize the large number of individuals who currently are admitted to high acuity services who are not eligible for or are not engaged with CRT services. These individuals may be too unstable at discharge to respond effectively to traditional outpatient referrals. Windham Center is proposing to create (or to partner with HCRS to create) a small intensive community based crisis intervention team (2 clinicians, 1 peer support specialist, and a part time prescriber) to provide coverage for these individuals in order to facilitate discharge from higher levels of care as well as to help prevent readmission.

This program is designed to be a medically monitored interdisciplinary team that is organized to provide intensive, flexible, and individualized interventions. Interventions may include 1:1, family support, home visits, and some crisis group work. The program is for individuals who present in a crisis but are able to continue to manage in the community and neither want nor need a structured program. Length of stay would be usually 1-6 months. The program is recovery oriented, trauma informed, co-occurring disorder capable, and medically integrated, with commonly peer support commonly incorporated as a critical feature. This type of service may be very flexible, based on the needs of the individual, and may consist of a few sessions followed by resolution of the crisis, or may provide a short-term bridge (ranging from a few weeks to a few months) to engagement in usual outpatient or CRT services. These services generally require

access to and involvement of medication prescribers and nursing support in order to adjust medications to help resolve the crisis, manage health related concerns, and help the individual achieve initial stabilization.

The most important aspect of the program is the capacity to engage individuals with very complex and unstable situations who are at risk for hospitalization and poor outcomes but who are not engaged in CRT services. The intensive community based crisis intervention team, like a CRT program, has the capacity to provide services that are matched to individual need, ranging from daily visits, intensive case management, and frequent medication monitoring, to weekly case management and peer support to help the person transition to more routine outpatient care. This type of program can be combined, if needed, with structured group programs such as partial hospitalization, DBT, or intensive outpatient, and may continue to work with clients who require brief periods of crisis stabilization in residential or inpatient settings.

As noted in the Vermont Care Management Report, this type of service is not currently available in the Vermont continuum of care for individuals who do not meet CRT, DS, or TBI eligibility criteria, but was identified as a significant gap by both providers and consumers. It has also been recognized as a significant gap in our own continuum of services, and we feel it is a cost effective mechanism of facilitating movement of consumers through the acute care continuum into more community based recovery services.

N.B. The three program elements listed above are the major new program components included in this concept proposal. In addition, we are providing brief descriptions of the current program components that we envision to be fully integrated on campus into the available continuum of care.

4. Outpatient Services

All outpatient services are recovery oriented, co-occurring, DBT and trauma informed. Our clinic offers:

- **Partial Hospitalization (PHP)**
  An intensive, short-term program designed to help people acquire coping skills and regain their ability to function. The PHP serves as an alternative to inpatient hospitalization; a transition from the hospital back to outpatient care; or supplies support and structure to prevent

further deterioration when less-intensive treatment cannot adequately meet the persons needs.

- **Intensive Outpatient Program (IOP)**
  A moderate-intensity program designed to help people cope with life circumstances and avoid relapse. The IOP serves as a step down from partial hospitalization to promote a safe transition back to outpatient care, or supplies support and structure to prevent further deterioration when less-intensive therapy cannot adequately meet the persons' needs.
- **Dialectical Behavior Therapy**
  DBT is a comprehensive, cognitive behavioral treatment program, providing people who have Borderline Personality Disorder (BPD), with the skills to regain control over their emotions and their lives.
- **Buprenorphine Therapy**
  A medication-assisted therapy, combined with 12-step recovery skills, to help people regain their functioning, avoid relapse, and improve the quality of their lives.
- **Outpatient Psychiatry**
  A traditional evaluation and medication management program delivered by psychiatrists and designed to help people continue recovery in the community
- **Outpatient Counseling & Psychotherapy**
  A traditional individual and group therapy designed to help people cope with life circumstances and improve life satisfaction. Current groups are Pain Management Support Group, Relapse Prevention Groups and DBT Applications Group. These services are available for those people who can achieve and/or maintain recovery in the community.

  The outpatient programs are existing programs that will remain unchanged in the continuum, except their physical location will be moved. (A more detailed description of programs is included in an Appendix to this proposal.)

C. Implementation Process and Timeline:

One of the strengths of the Springfield Medical Care Systems/Windham Center proposal is no requirement for significant new construction or a requirement to obtain a significant regulatory change. Implementation can occur relatively quickly.

We are ready to engage in the planning process once we have come to agreement and we envision that once we have approval to proceed (and the timing of that may depend on whether a Certificate of Need is required for any aspect of this proposal) the renovation of the existing space could be completed in approximately six months. Recruitment for new staff, particularly medical staff, would begin immediately, but we would expect that the recruitment, hiring, and training processes, as well as the development of all the protocols for the new programs, would be completed in about twelve months from initial approval, or about six months following completion of the space renovation.

We would want to work in partnership with DMH and other stakeholders to organize the most effective process of implementation. One strategy that we have considered, that may permit a faster, and smoother, implementation process, is to have a phased transition from the current Windham Center operation to the new configuration. This might involve the initial implementation of a 4-bed ICU component within the 10-bed Windham Center along with opening a 4 bed CSU in the building across the parking lot. Once these services were up and running for a few months and all the initial procedural challenges had been worked out we could then proceed to roll out the complete project.

D. Program of Space:

The following discussion includes a general description of the space plan for the 10-bed inpatient unit and the 10-bed crisis stabilization unit followed by more specific details and drawings. It is our intent (and we have the capability in our space) to meet and exceed all the requirements outlined in the proposal. We do not, as yet, have comprehensive community planning, nor do we have comprehensive architectural plans, so our discussion below a conceptual framework. Nonetheless, our space design and our cost estimates have been reviewed with the SMCS Director of Facilities so that we have received approval regarding initial feasibility of this design.

1. **10-Bed Acute Psychiatric Inpatient Unit (ICU):** The Windham Center proposal is to utilize the current inpatient unit space (7500 square feet), its contiguous outdoor space (8000 square feet), and to re-configure existing space in the Health Center at Bellows Falls to add an additional wing (3500 square feet) into the footprint of the unit. (See attached diagram). The unit would undergo renovation so that all of the space met appropriate regulatory, code, and safety criteria for a locked inpatient unit including incorporation of the latest advances in recovery oriented environmental design, as well as meeting all the goals and objectives specified below.

   This space proposal is purely conceptual and has not yet undergone a complete planning process with the owner of the building (Greater Rockingham Area Services), current tenants, and other community stakeholders.

   The current Windham Center space is already designed to have a home-like, family atmosphere that has been well recognized and appreciated by both consumers and families. We intend to maintain the same atmosphere in the design of all of our space. The plan is to have 10 single rooms with en suite bathrooms, two of which would be configured with medical bed capacity, two "quiet rooms" for assistance to consumers who need to be in a secure, supported place to maintain safety, an admission evaluation area, (with a medical examining room), as well as a comprehensive array of community, group, and program space, including an indoor exercise area. There will be two nursing stations, so that, if needed, the 10 bed unit can be subdivided into 6 and 4 or 8 and 2, as indicated to manage subgroups of different levels of acuity, or to help protect more vulnerable consumers from those who may be more agitated and violent.

We intend to maintain the on-site kitchen that is well known for the quality of "home cooking" that is provided under oversight of a registered dietitian. In addition, we plan to add additional square footage (approximately 1500 square feet) to the outdoor recreational space, which will be security-enhanced. We will put in an additional entrance to that space, so that we can use that space for different subgroups of consumers who may be in different sections of the unit.

There is access for ambulance admissions through the rear of the building, and we can provide a secure passageway from that entrance into the secure inpatient unit. We will incorporate a number of enhancements to security, including video monitoring, secure elevators, and so on.

Finally, the expanded space will include offices for program leadership, physicians, and clinicians, as well as provision for an on-call room for overnight doctors, and the ability to use one of the larger group rooms or conference rooms as a secure access courtroom. We will also have the ability to set up off unit visitation areas.

2. **10-Bed Medically Monitored Crisis Stabilization Unit:**
The Windham Center current proposal is to completely renovate an existing two story wood frame mixed use building (apartments, credit union, offices) on campus, across the parking lot from the inpatient unit, into a safe, 10 bed crisis stabilization unit integrated with a range of intensive outpatient programs. This proposal is purely conceptual, and has not yet undergone a complete planning process with the owner of the building, current tenants, and other community stakeholders. This building, like the Health Center at Bellows Falls, is owned by Greater Rockingham Area Services (GRAS), and we would work with GRAS and any existing tenants to develop an appropriate planning process, finalize any decisions about use of space, and to create a transition plan.

Conceptually, our goal would be to create a home-like residential environment, with a mixture of one bed and two bed rooms (perhaps 4 singles and 3 doubles). Bedrooms would be on both floors. The CSU space would include one kitchen/dining area, and living areas, program space, and staff space on both floors. There would be a medication storage area, and "nursing space", in which consumers would be assisted to take their prescribed medications. All space would be renovated for safety, and the first floor would be made fully handicapped accessible.

In addition, we would renovate existing office space (e.g., the credit union space) to hold waiting areas, program space and staff offices for the bulk of our outpatient programs (PHP, IOP, DBT, buprenorphine groups), including the intensive case management team. We would also make provision for a physician office on site. This would permit a richer staffing mix in the building, as well as facilitate integration between CSU and outpatient services. Our goal would be to make it very easy for individuals in CSU to have access to programming they may need, while not requiring anyone to have to attend programming they do not need.

E. Programming and Staffing Plan:

The following discussion includes a general description of the staffing plan for the proposed expansion of the overall psychiatric continuum, including administration and quality oversight, 10-bed acute inpatient ICU unit, 10-bed CSU, and intensive crisis case management. In each section, there will be an outline of the staffing model, and how the staffing mix is intended to meet various needs of the project. In the sections on the two 10-bed units, the general outline of staffing will be followed with a more detailed discussion of staffing ratios and staffing mix on each shift.

1. Administration of the Program: The size and complexity of this proposal will require that SMCS provide the requisite clinical and administrative oversight support to ensure successful clinical and programmatic outcomes in a very complex system. In the past two years, as our psychiatric programs have contracted, we have essentially "done without" a level of infrastructure that would be needed in a larger and more complex operation, including eliminating our "program director" position (3 years ago), operating while recruiting a medical director (1 year), and borrowing limited resources from the rest of the hospital for training, quality improvement, and fiscal support. We would not be able to sustain the current project without dedicated staff to ensure that the larger administrative and quality issues are attended to, that we have the utilization management capability to link with the DMH system as a whole and facilitate movement through our continuum, and that the training/ retraining of staff in the most up-to-date intervention strategies can be provided with adequate intensity. Consequently, with this project we would need:

- 1 FTE Program Director for Behavioral Health
- 0.5 FTE (non-direct service time) Medical Director for Behavioral Health
- 1 FTE Quality Improvement/Utilization Manager for Behavioral Health (RN)
- 0.5 FTE Behavioral Health Training Specialist (RNCS)
- 0.5 FTE Consumer/Family Advocacy Director
- 1 FTE Behavioral Health Fiscal/Billing Specialist
- 1 FTE Support Staff
- Mental Health Legal Consultation as needed

2. 10-Bed Acute Psychiatric Inpatient Unit (ICU): Our general goal in staffing this program is to meet or exceed all the nursing/staffing ratios outlined in the proposal, to incorporate consumer peer specialists on every shift as an integral part of recovery oriented staffing, to ensure all staff are recovery oriented,

trauma informed, and co-occurring competent, to develop effective interdisciplinary treatment teams that work in partnership with consumers, families, and community providers, to provide 24 hour on site psychiatric coverage, to provide round the clock on site (non-uniformed) security, and to involve staff in providing a comprehensive array of recovery programming, both individually and in groups, designed for individuals who may have severe psychiatric conditions, as well as complex co-occurring substance use, cognitive, and other issues.

In addition, we are providing staffing and other resources to establish our ability to maximize the capability of the unit to respond to individuals with both acute and chronic medical needs, and to most effectively engage the more comprehensive resource base of the Springfield Hospital medical facilities.

The general plan is as follows:

We would have 2 FTE psychiatrists, each of whom would provide 0.75 FTE for the acute unit, and 0.25 FTE elsewhere in the continuum. Each psychiatrist would be in charge of one interdisciplinary team. In addition, we would arrange for on site psychiatry coverage 24 hours/day, 7 days/week by hiring residents to cover (as is currently done in other hospitals in our geography). There would be a full time nurse manager, as well as nursing staff and peer support coverage as described in the staffing chart below. We would have one FTE social worker, and one FTE peer specialist for each team, as well as assigned nurses. In addition, the unit would have a full time OTR or similar position to organize, plan, and provide programming, particularly for designing programming and skill building for individuals who may be severely psychotic or cognitively impaired. We would also have a substance abuse specialist, as a resource, to support co-occurring capability in all staff and programming. Finally, we would have an array of dietary staff, and unit support staff, as described in more detail below.

Ten Bed ICU	RN	MHW	Peer Support
Day	4	7	1
Evening	4	8	1
Nights	4	7	1

Registered Nurse	11.0 FTE's
Mental Health Worker	30.2 FTE's
Peer Support Specialist	4.3 FTE's

This staffing pattern would be designed to support a full array of programming for individuals who are acutely ill, and who have complex co-occurring substance use, medical, and/or cognitive impairments. The current Windham Center programming emphasizes recovery skill building for both mental health and substance use issues, and involves activities for the purpose of social skill development and self-esteem building.

However, our plan would be to design the program content to build on what we already provide, but to have the capacity to adapt the content of the material based on the cognitive abilities of the consumers on the unit. The goal of all programming, however, would be to emphasize hope and recovery, and to help each consumer identify specific illness management or support development skills that would promote recovery (in relation to mental illness, substance use, health, etc.), and then work on practicing and learning those skills in the inpatient unit. Please see "Windham Center Group Schedule" in the Appendix.

Medical Capacity: In order to enhance our medical capacity to support the "no reject" policy, we will plan to hire a full time FTE medical physician or nurse practitioner to attend to medical issues on the unit. We will train all (or most) staff to be able to monitor vital signs, and to perform basic medical testing, such as EKGs, and we will have staff trained as phlebotomists as well. We will have formal training in responding to a "code", and have a basic code cart on the unit. During the day, the medical resources of the Walk In Clinic are on site. Further, we will have 24 hour transport capability, in order to bring stat labs to the hospital, bring in X-Ray technicians to do X-rays, and to transport patients who might need a more urgent high level intervention to the Springfield ER (but who may not need an ambulance). (Note that we can get someone emergency admission to our own ER in 20 minutes. Negotiating a similar transfer from an in house psychiatric unit to its own ER will often take at least as long).

Recruitment: As noted in the introduction, Windham Center has an exemplary track record of attracting and retaining staff, including nursing staff, with very low turnover. The reason for this is that we emphasize a recovery culture that involves and empowers staff, as well as consumers, so that working on the unit is a positive experience, and involves a sense of collaboration and teamwork at all levels of management and staff. We also have considerable experience, and success, recruiting, and training, medical surgical nurses to come to work in psychiatry. Nonetheless, we know that it will take time to recruit and train the

volume of new staff that we will need to begin these new programs.

The next issue would be the recruitment and training of peer specialists. We would hope to work in partnership with both DMH and VPS to develop a recruitment and training plan for consumers who might be interested in these exciting, but challenging positions, and to help design job descriptions that will help them be successful, and help them promote engagement and recovery in the very challenging group of consumers who would be admitted to the unit.

The biggest challenge we anticipate in implementation of this proposal would be recruitment of psychiatrists. Again, we have been very successful in retaining psychiatric staff, but the key issue is attracting psychiatrists (or psychiatric nurse practitioners) to southeastern Vermont. We have the capacity to put together a very attractive salary and benefit package. In addition to this, we would hope to work actively in partnership with DMH to create a multidimensional recruitment package that would make it more appealing for individuals who may have trained in the Burlington area or at Dartmouth to relocate to Bellows Falls, including offering University appointments, faculty mentorships, and so on, in order to help the psychiatrists that we are working with at the Windham Center feel part of a community of psychiatrists across the state, who are working on a common mission.

3. **10-Bed Medically Monitored Crisis Stabilization Unit:** Our general goal in the CSU is to create a richly staffed interdisciplinary team that can work in partnership with clients in crisis to stabilize acute psychiatric and substance use issues, manage medical concerns, provide support, facilitate crisis resolution, and create a transition plan that helps the consumer (and family) re-engage with existing community and peer support.

   The general staffing plan is as follows, with a more detailed chart below.

   We will have a full time master's level program manager, one full time RN, plus coverage RN 8 hours per day on weekends and holidays, and available telephone support 24 hours/day, 7 days/week. There will be a psychiatric consultant available to the team 8 hours per week, plus there will be direct psychiatric service available every day on site in the outpatient clinic (approximately 1-2 hours per day). The program will have a full time social worker to provide individual and group interventions, and to organize crisis intervention and transition planning. Each shift will

have a combination of mental health workers and peer support specialists, as described below. Finally, the program will have support staff and maintenance staff, as further delineated in the staffing plan below.

All staff will be trained to be recovery-oriented, trauma informed, and co-occurring capable, with basic skills in taking vital signs, managing uncomplicated detoxification, and safe de-escalation and engagement.

Ten Bed Crisis Stabilization	RN	Mental Health Worker	Peer Support
Day	1	2	1
Evening		2	1
Nights		2	

Registered Nurse	1.4 FTE's
Mental Health Worker	8.4 FTE's
Peer Support Specialist	2.8 FTE's

Programming content in the CSU itself will be relatively low intensity, with one group daily in the day shift, and one in the evening shift, emphasizing community issues, and basic crisis planning (day time), and recovery support in the evening. All consumers will have availability and choice regarding participating in additional programming, as indicated, including PHP, IOP, OP groups, DBT (all on site), as well as, where feasible, participating in individual, group, or family sessions with their existing treaters (e.g., their existing CRT team). In this fashion, the program will have the flexibility to provide services matched effectively to individual need. With regard to program content, the existing array of groups has evolved to be co-occurring capable, recovery oriented, and solution focused. Adaptations can be made easily, based on the mix of clients on any given day.

4. **Intensive Crisis Case Management Team:** As noted above, Windham Center is proposing to create (or to partner with HCRS to create) a small intensive community based crisis intervention team (2 clinicians, 1 peer support specialist, and a part time prescriber) to provide coverage for these individuals, in order to facilitate discharge from higher levels of care, as well as to help prevent readmission.

   The general description of the program's operation is described above. The staffing levels would be flexible based on volume, perhaps starting with two 0.5 FTE clinicians, 1.0 FTE peer

specialist, and 0.1 FTE psychiatrist or nurse practitioner (to manage 10-20 clients) and then having the potential to double in size if the case load warranted.

F. Licensure and Governance:

Springfield Medical Care Systems (SMCS) is a non-profit corporation directed by a dedicated Board comprised of patients and community members. SMCS is designated as a Federally Qualified Health Center. Springfield Hospital is a subsidiary of SMCS governed by its own board of directors. The hospital board of directors is comprised of local citizens of our region, who volunteer their time to establish policy, create and monitor a strategic plan, approve budgets and make critical decisions regarding the implementation of our mission. Through the direct participation of community members on our board, our community has input into both setting and monitoring the strategic direction and decision making of Springfield Hospital.

The Vermont State Hospital Replacement Beds at the Windham Center would be under the governance of the Springfield Hospital Board of Directors. Springfield Hospital would hold the license to operate the replacement beds. The license to operate the Crisis Stabilization Unit would be the responsibility of Springfield Medical Care Systems. We believe that the separation of licensure will assist in clarifying that the Crisis Stabilization Beds are residential beds and should not be confused as acute inpatient psychiatric beds. As a Critical Access Hospital we are limited to a 10-bed distinct part unit for acute inpatient psychiatric beds. The Crisis Stabilization Beds would therefore be under the governance of the Springfield Medical Care Systems Board of Directors. Although the two entities may be under two different boards we do not feel this would be an issue in looking at behavioral health as its own service line and continuum of care.

Currently, the Windham Center is managed with Co-Directors who report to the Chief of Patient Care Services. The Chief of Patient Care Services reports directly to the Chief Executive Officer. The position of Medical Director of the Windham Center also reports to the Chief of Patient Care Services. The continuum we are proposing would include some additional administrative infrastructure to support the program. The entire continuum would have a full time Program Director and a Medical Director. In addition, each piece of the continuum would have the appropriate management to support its work as discussed earlier in this proposal. The Program Director and Medical Director would report to the Chief of Patient Care Services.

G. Program Costs and Program Revenues: In the following pages please find expense and revenue numbers we have created based on the attached proposal for a continuum of care to replace Vermont State Hospital beds. Again, this is a conceptual proposal. If the Department of Mental Health wishes to partner with us in this work we would need to do a more thorough financial analysis. As we said earlier in the proposal we would expect to be working together in good faith toward a financial model that insures the continuance of resources to support our commitment to the program and the population of individuals we are serving.

Capital expenses: Our proposed plan is to renovate existing space at the Health Center at Bellows Falls which is approximately 1500 square feet at about $180 per square foot. In addition to that renovation 3500 square feet of space would be remodeled at about $280 per square foot. The addition of this square footage would bring Windham Center up to 11,000 square feet. The Credit Union building would be remodeled to house the Crisis Stabilization Unit as well as program space. The estimate for renovation for those 7000 square feet is at about $175 per square foot. Our Director of Facilities created this estimate for us based on extensive experience with past renovations. Again, formal analysis of the space and expense would need to be performed if our conceptual proposal moves forward to an actual bidding process.

In addition to actual renovation of space capital expenses would include room furnishings and equipment. We have also included a van to provide the transportation we feel is needed to meet care needs along the continuum.

We fully realize that these capital expenses are estimates and may change as a more in depth plan progresses.

Statistics: In computing our Psychiatric Acute Care Days we estimated 240 admissions if the 10 beds become VSH replacement beds. The average length of stay was estimated at 13.2 days with the knowledge the length of stay may vary significantly to either side of this estimate. Occupancy rate was calculated at 86.85% using the above information with the understanding we would be striving for 90% occupancy.

Income statement: For the inpatient replacement beds we have projected expenses in the areas of wages, physician wages, rent, other expenses including utilities, and security. We have based our wage estimates on current wages being paid to similar disciplines in our organization. Wages are calculated using the various staffing models addressed earlier in the proposal.

Expected expenses for the Crisis Stabilization Unit include wages, physicians, rent, and other expenses calculated using similar information to that used to calculate expenses for the inpatient unit.

The revenue projections for the inpatient replacement beds assume payments of $1283 per day for each occupied bed. Based on revenue projections and expenses for the inpatient replacement beds we would expect a surplus of $678,096. The Crisis Stabilization Unit is an integral part of the continuum of care we are proposing. We expect that we would be reimbursed for those beds as part of providing the opportunity to step individuals through various levels of care based on their needs. As a starting point we have discussed the need for $627 a day per occupied Crisis Stabilization bed. Based on an 80% occupancy rate, the revenue we have projected, and the expenses we would expect a surplus of $305,140.

We would look forward to further discussion around expenses and revenues if this proposal is accepted to move on to a bidding process.

Capital Expenses

Remodel 3,500 square feet of new space at Health Center at Bellows Falls	$875,000
Remodel 1,500 square feet of existing space at Health Center at Bellows Falls	270,000
Remodel 7,000 square feet of Credit Union building for Crisis Stabilization Unit	1,225,000
Total for building renovations	$2,370,000
Room furnishings	$51,000
Equipment	30,000
Van	30,000
Total for furnishings and equipment	$111,000
Total for capital improvements and equipment	$2,481,000

Psychiatric Acute Care Days

Psychiatric Admissions	240
Length of Stay	13.2
Total Psychiatric Patient Days	3,170
Occupancy Rate	86.85%

Income Statement

VSH Replacement Beds Inpatient	**Proposed**
Net Revenue	$4,068,574*
Wages	1,773,243
Physicians	428,000
Rent	132,000
Other	322,235
Indirect Expenses	435,000
Security	300,000
Total Expenses***	$3,390,478
Net Income	$678,096

Crisis Stabilization Unit	**Proposed**
Net Revenue	$1,830,839**
Wages	736,000
Physicians	338,500
Rent	84,000
Other	152,199
Indirect Expenses	215,000
Total Expenses***	1,525,699
Net Income	$305,140

*Assumes payment of $1283 per day per VSH replacement bed occupied

**Assumes payment of $627 per day per Crisis Stabilization bed occupied

***Reflects no interest or depreciation expense. Presumes DMH pays for capital improvements

H. **Impact:** The Windham Center continuum has long represented a very significant component of the Springfield Medical Care Systems array of services, and significant portion of the total operating bed capacity. This project however would significantly expand the importance of behavioral health within the total operation of SMCS, both financially and programmatically. From our perspective this would be a positive step, not just because of the opportunity to partner with DMH to achieve the specific goals of the Futures Project, but also because of our recognition of the importance of integration of behavioral health services into all of our existing services: emergency room inpatient medical services, primary care offices, pain management, and so on. In addition, our transition to FQHC status has made us more attuned to the extent to which it is a priority for HRSA to integrate behavioral health into all aspects of FQHC operation. Consequently, this project can provide SMCS the opportunity to elevate the capacity of our own behavioral health continuum in a way that serves not only the needs of the project, but is supportive of the whole SMCS "community" and the needs of our catchment area generally.

On the other hand, we have given considerable thought to the fact that the project essentially replaces the current Windham Center inpatient unit program. This is an issue for DMH, of course, in that it removes 10 general hospital beds from the current mix. It is also a concern for SMCS. The Windham Center inpatient unit is, and has been, a very successful program, both clinically and financially, for the hospital. The program is very well recognized, and serves an important function for our community, for the many patients who need hospital level of care most of whom would never be admitted to VSH. The biggest risk for SMCS in this process is that we lose the current version of the Windham Center, put a lot of work into the new continuum of services, and wind up feeling that we are worse off than when we started, both programmatically and financially.

Consequently, we have incorporated into our conceptual proposal an approach which we hope would be a win-win for both us and DMH: namely, the development of the 10-bed Crisis Stabilization Unit. This would create much less of an overall impact on the state's hospital bed capacity, as well as continuing to effectively serve our community. Further, insofar as our initial mission (prior to obtaining Critical Access Hospital status which limited our bed capacity) was to develop 20 psychiatric beds (and we still hold a license for 20 beds), this configuration of services allows us to move in the direction of that vision, while providing what we hope would be a more seamless service continuum for consumers in need of acute care.

I. **Financials:** Springfield Medical Care Systems is opting to not include audited financials in this conceptual proposal. The proposal and any documents submitted with it become available for public review. During the early stages of reviewing our conceptual proposal we feel it is not necessary for these documents to be made public. We fully understand that we will need to share some of that information if our conceptual proposal moves to a bidding process.

III. Guiding Principles:

We want to take the opportunity in this section to formally express our commitment to the Collaboration Principles articulated in the RFP.

We are committed to the principles of designing consumer-driven, recovery oriented, integrated programs that provide high quality clinical care, and to integrating our programs within the larger processes of the Vermont Adult MH Care Management Delivery System.

We are committed to transparent governance, collaborative fiscal partnership, and collaboration throughout the process of planning, permitting, renovation, and operation.

Further, we are committed to engaging our stakeholders as partners in the design and quality oversight of the program. About 12 years ago, when we first began the process of upgrading the services at the Windham Center, we created a community stakeholder group (including representation from HCRS, NAMI, VPS, etc.) that was termed: Quality Council. The purpose of this group was to create a formal mechanism for community representatives to express concerns, help design operations and programming, etc, so that any changes in the unit would be responsive to the needs of the community. This Quality Council was very successful in building a sense of partnership and ownership that continues to this day (and the Quality Council eventually was disbanded, as it had achieved its objectives). We are proposing, in the context of this project, to create a newly formed Quality Council that would serve a similar purpose for the new continuum of care, and once again create a formal mechanism for stakeholder input, advocacy, and quality improvement.

IV. Conclusion: Springfield Medical Care Systems and the Windham Center welcome the opportunity to submit this conceptual proposal, and look forward to continuing conversations and partnership, as we work together with DMH and other stakeholders in the process of developing integrated, recovery oriented services for individuals and families with behavioral health needs in Vermont.

Appendix

Appendix A

Windham Center Outpatient Programs

WINDHAM CENTER OUTPATIENT PROGRAMS

PARTIAL HOSPITALIZATION PROGRAM (PHP)

The Windham Center Partial Hospitalization Program (PHP) is an intensive, short-term program designed to help people with mental health issues cope with life circumstances, regain functioning, and improve the quality of their lives. The PHP serves as an alternative to inpatient hospitalization or a transition from the hospital back to outpatient providers, or supplies support and structure to prevent further deterioration, when less intensive services cannot adequately meet the individual' needs. With rapid, easy access, people are assessed and admitted into the program within 72 hours of referral.

Program: Short Term – 2-4 weeks
Intensive – 5 hours per day, 3-4 days per week
Open Monday – Friday 8:00 am to 4:00 pm.
Comprehensive co-occurring model of treatment includes:

- Psychosocial Assessment
- Medication Monitoring
- Comprehensive Treatment and Discharge Planning
- Community Care Provider Integration
- Individual Counseling, As Needed
- Family Counseling, As Needed
- Group Counseling

Participants: PHP participants comprise men and women who are over 18 and require intensive, structured programming and monitoring to maintain safety and avert further decompensation and subsequent hospitalization and can maintain, with this support, safety on an outpatient basis. More specifically, the PHP treats patients with a variety of issues such as:

- Adjustment Disorder
- Anxiety Disorders
- Mood Disorders (Depression/Mania)
- Personality Disorder
- Substance Use Disorder

INTENSIVE OUTPATIENT PROGRAM (IOP)

The Windham Center Intensive Outpatient Program (IOP) is a moderate intensity program designed to help people with co-occurring/mental health issues cope with life circumstance, regain functioning, avoid relapse, and improve the quality of their lives. The IOP serves as a step down from the Partial Hospitalization Program (PHP) to promote a safe transition back to outpatient providers or supplies support and structure to prevent further deterioration, when less intensive outpatient services can not adequately meet the patient's needs. With rapid, easy access, patients are assessed and admitted into the program within 72 hours of referral.

Program: Short Term – 2-6 weeks
Moderate Intensity – 3 hours per day, 3-4 days per week
Open Monday – Friday 8:00 am to 4:00 pm.
Comprehensive co-occurring model of treatment includes:

- Psychosocial Assessment
- Comprehensive Treatment and Discharge Planning
- Community Care Provider Integration
- Individual Counseling, As Needed

DIALECTICAL BEHAVIORAL THERAPY (DBT)

The Windham Center Dialectical Behavior Therapy (DBT) is a comprehensive cognitive behavioral treatment program providing people who have Borderline Personality Disorder (BPD) with healthy coping skills to regain control over their emotions and their lives. DBT was developed by Dr. Marsha Linehan at the University of Washington and has been shown through controlled clinical trials to be an effective treatment for BPD. DBT is presently being researched for the treatment of other disorders.

Program: Intermediate Term – 6 months
Moderate Intensity – Group: 2 hours per day, 2 days per week
Individual Therapy: 1 hour per day, 1 day per week
Attendance – Six month commitment with 72 sessions
Open Monday – Friday 8:00 am to 7:00 pm.
Comprehensive treatment includes:

- Psychiatric Consultation
- Diagnostic Interview
- DBT Consultation Team
- Individual Therapy Sessions
- Skills Training Groups
- Skills Applications Groups
- Family Education Group

Participants: DBT participants comprise men and women over 18 who suffer from BPD resulting in severe deficits in behavioral coping skills and require more intensive treatment than traditional outpatient therapy can provide.
Specific problems addressed include:

- Suicidal Behavior
- Self Harm Behavior
- Unstable Relationships
- Self- Image
- Impulse Control
- Emotion Regulation
- Feelings of Emptiness
- Anxiety
- Anger
- Post-Traumatic Stress Disorder

BUPRENORPHINE PROGRAM

The Windham Center Buprenorphine Program is a long-term, outpatient treatment program that combines opioid replacement therapy with 12-Step recovery skills to help people recover from opioid dependence, regain functioning, avoid relapse, and improve the quality of their lives. The program adheres to the philosophy that opioid dependence is a chronic, incurable, and often lethal disease, living with which demands an individualized, comprehensive program of recovery that includes pharmacological, behavioral, psychological, and spiritual interventions. Lastly, while no single treatment approach or medication is effective in all cases, maintenance therapy is safe and effective for those who are unable to maintain abstinence.

Program: Long-Term – Over 6 Months
Low Intensity - 1 hour per day, 1 day per week
Open Monday – Friday 8:00 am to 5:00 pm.
Comprehensive co-occurring model of treatment includes:

- Initial Psychiatric Evaluation
- Psychosocial Assessment
- Comprehensive Treatment Planning
- Initial and Random Drug Screenings
- Consent to talk with all other providers, officials and involved family members
- Medication induction with 2-3 daily visits in first week of treatment
- Weekly to monthly prescriptions written during individual or group sessions
- Weekly to monthly Bupe Group attendance
- Weekly to monthly individual counseling, as needed
- Weekly 12-Step program attendance

Participants: Program participants comprise men and women who are over 18 and actively opioid dependant, currently in Methadone maintenance or have a history of opioid dependence and are at high risk for relapse. More specifically, the Buprenorphine Program treats patients with opioid dependence and co-occurring disorders, such as:

- Adjustment Disorder
- Anxiety Disorders
- Mood Disorders (Depression/Mania)
- Personality Disorders
- Psychotic Disorders
- Substance Use Disorders

Federal law limits the number of people in treatment to 100 patients per provider, which typically results in a long waiting list. Preference is given to residents of Windham and Windsor Counties.

Referral and Contact Information
Referrals to all programs are welcomed from medical, mental health, drug and alcohol, and Employee Assistance Professionals. To make a referral to any of our programs or for further information, please call Shari Yates, Administrative Coordinator at 802-463-1292.

Many third party payers, including private insurers and Medicare and Medicaid may help cover the cost of the programs. Individual financial arrangements can also be made and in some cases financial assistance is available.

Program Staff: William Grass, MD, Psychiatrist and Addictionologist; Ray Abney, MD Psychiatrist; Jean Etter, LICSW, Co-Director; Carol Hoyt, LCMHC; Sandra Cotter, LADC; John Herscher, LICSW; Janet Farley, LICSW; Sandra Zawalick, LICSW and Therese Zocchi, MA.

Appendix B

Windham Center Group Schedule

WINDHAM CENTER GROUP SCHEDULE

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TIME	SATURDAY	SUNDAY
7:00am	BREAKFAST					7:00am	BREAKFAST	
	ADL ASSIST AS NEEDED – ASK IF YOU NEED HELP WITH LAUNDRY, SHOWER, ETC.							
9:00am	GOALS/COMMUNITY MEETING					9:30am	GOALS/COMMUNITY MEETING	
10:00am	JOURNAL GROUP	LEISURE EDUCATION	LEISURE PRACTICE SKILLS	EXERCISE GROUP	NEWSPAPER GROUP	10:00am	EXERCISE GROUP	
11:00am	LEISURE EDUCATION	NUTRITION EDUCATION	DBT: DISTRESS TOLERANCE	LEISURE EDUCATION	ORIENTATION OR FOCUS	11:00am	JOURNAL GROUP	
12noon	LUNCH					12NOON	LUNCH	
1:00pm	COGNITIVE OR FOCUS	MOOD DISORDER OR FOCUS	COGNITIVE GROUP OR FOCUS	COPING SKILLS OR FOCUS	AGENDA GROUP	1:00pm	COGNITIVE GROUP	SPIRITUALITY GROUP OR COGNITIVE
2:00pm	DBT: MINDFULNESS	TAI CHI MEDITATION	AGENDA GROUP	TAI CHI MEDITATION	HUMOR GROUP	2:00pm	ACTIVITIES	
3:00pm	VISITING HOUR/FREE TIME					3:00pm	VISITING HOUR/FREE TIME	
4:00pm	ASSERTIVENESS OR ANGER MANAGEMENT	MEDICATION GROUP	ADDICTION'S GROUP	COGNITIVE GROUP	RELAPSE PREVENTION	4:00pm		
5:00pm	SUPPER					5:00pm	SUPPER	
6:00pm	VISITING HOUR/FREE TIME					6:00pm	DBT: DISTRESS TOLERANCE OR COPING SKILLS	Smart Choices Activities /leisure skills Group
7:00pm	RELAXATION SKILLS	WELLNESS GROUP (MINDFULNESS) OR NA	COMMUNICATION SKILLS GROUP OR AA @ 6:30 pm	JOURNAL GROUP OR GUIDED IMAGERY OR AA	SLEEP HYGIENE OR AA	7:00pm	SATURDAY NIGHT SOCIAL	7:15 WRAP-UP 7:30 MOVIE NIGHT
8:15pm	WRAP-UP GROUP					8:15pm	WRAP-UP	
	SLEEP HYGIENE: ASK STAFF FOR BEHAVIORAL OPTIONS THAT ENCOURAGE HEALTHY SLEEP ROUTINES							

WINDHAM CENTER TREATMENT TEAM SCHEDULE

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TIME	SATURDAY	SUNDAY
9:30am TIL NOON	CLINICAL ROUNDS /TREATMENT PLANNING MEETING (Daily Medical/Psychiatric/LOC reassessment)					9:30am	CLINICAL ROUNDS /TREATMENT PLANNING	
	Treatment team Members: Psychiatrist/Nurse Practioner, Peer Support Specialist, RN, MSW, Certified Recreation Therapist							
	with administrative staff as needed							

Acknowledgement

We would to acknowledge that we have reviewed and integrated some of the care management principles from the following document into our proposal:

Report on Clinical Services Design For the Vermont Adult Mental Health Care Management System. The Center for Health Policy, Planning, and Research; University of New England. May 2009.